		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043406

Facility Name: WOODSIDE EXTENDED CARE

Address: 120 WEST 26TH ST (Number) SO.CHICAGO HTS. (City) 60411 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 39-4153529

Date of Initial License for Current Owners: 11/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MANAGER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,360	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	793		2,150	2,943	8
9	SNF/PED					9
10	ICF	36,625	330		36,955	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,418	330	2,150	39,898	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.60%

D. How many bed-hold days during this year were paid by Public Aid?
691 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided _____

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	148,053	11,711	12,170	171,934		171,934		171,934			1
2	Food Purchase		138,602		138,602		138,602	(604)	137,998			2
3	Housekeeping	94,899	13,370		108,269		108,269		108,269			3
4	Laundry	35,129	10,576	7,210	52,915		52,915		52,915			4
5	Heat and Other Utilities			94,845	94,845		94,845	227	95,072			5
6	Maintenance	31,189	17,460	20,820	69,469		69,469	868	70,337			6
7	Other (specify):* SECURITY SALARI	8,302		6,315	14,617		14,617	77	14,694			7
8	TOTAL General Services	317,572	191,719	141,360	650,651		650,651	568	651,219			8
	B. Health Care and Programs											
9	Medical Director			9,125	9,125		9,125		9,125			9
10	Nursing and Medical Records	1,048,622	72,762	14,953	1,136,337		1,136,337		1,136,337			10
10a	Therapy	50,788		1,000	51,788		51,788		51,788			10a
11	Activities	74,071	3,968	2,856	80,895		80,895		80,895			11
12	Social Services	14,950		4,616	19,566		19,566		19,566			12
13	Nurse Aide Training											13
14	Program Transportation			4,002	4,002		4,002		4,002			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,188,431	76,730	36,552	1,301,713		1,301,713		1,301,713			16
	C. General Administration											
17	Administrative	88,515		223,000	311,515		311,515	(135,059)	176,456			17
18	Directors Fees											18
19	Professional Services			32,373	32,373		32,373	5,524	37,897			19
20	Dues, Fees, Subscriptions & Promotions			38,492	38,492		38,492	(32,634)	5,858			20
21	Clerical & General Office Expenses	88,785	19,491	71,896	180,172		180,172	(28,669)	151,503			21
22	Employee Benefits & Payroll Taxes			270,763	270,763		270,763		270,763			22
23	Inservice Training & Education			2,512	2,512		2,512	47	2,559			23
24	Travel and Seminar							50	50			24
25	Other Admin. Staff Transportation			3,874	3,874		3,874	366	4,240			25
26	Insurance-Prop.Liab.Malpractice			87,712	87,712		87,712	1,430	89,142			26
27	Other (specify):*			17,288	17,288		17,288	(12,126)	5,162			27
28	TOTAL General Administration	177,300	19,491	747,910	944,701		944,701	(201,071)	743,630			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,683,303	287,940	925,822	2,897,065		2,897,065	(200,503)	2,696,562			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WOODSIDE EXTENDED CARE #0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			29,995	29,995		29,995	(10,543)	19,452			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,038	26,038		26,038	1,064	27,102			32
33	Real Estate Taxes			259,409	259,409		259,409	628	260,037			33
34	Rent-Facility & Grounds			563,803	563,803		563,803		563,803			34
35	Rent-Equipment & Vehicles			34,909	34,909		34,909	2,441	37,350			35
36	Other (specify):* OFFICE RENT			7,784	7,784		7,784	(7,669)	115			36
37	TOTAL Ownership			921,938	921,938		921,938	(14,079)	907,859			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		47,970	47,944	95,914		95,914		95,914			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		47,970	109,264	157,234		157,234		157,234			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,683,303	335,910	1,957,024	3,976,237		3,976,237	(214,582)	3,761,655			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(11,514)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(604)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(200)	20		17
18	Fines and Penalties				18
19	Entertainment	(27,818)	20		19
20	Contributions	(4,754)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,288)	27		24
25	Fund Raising, Advertising and Promotional	(145)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(495)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(996)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,814)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(150,768)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (150,768)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (214,582)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WOODSIDE EXTENDED CARE

ID# 0043406

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (996)	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(996)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(604)	0	0	0	0	0	0	0	0	0	0	(604)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	227	0	0	0	0	0	0	0	0	227	5
6	Maintenance	(996)	1,471	393	0	0	0	0	0	0	0	0	868	6
7	Other (specify):*	0	77	0	0	0	0	0	0	0	0	0	77	7
8	**TOTAL General Services**	(1,600)	1,548	620	0	0	0	0	0	0	0	0	568	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	5,681	(140,740)	0	0	0	0	0	0	0	0	(135,059)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,216	308	0	0	0	0	0	0	0	0	5,524	19
20	Fees, Subscriptions & Promotions	(33,412)	778	0	0	0	0	0	0	0	0	0	(32,634)	20
21	Clerical & General Office Expenses	0	18,465	(47,134)	0	0	0	0	0	0	0	0	(28,669)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	47	0	0	0	0	0	0	0	0	0	47	23
24	Travel and Seminar	0	50	0	0	0	0	0	0	0	0	0	50	24
25	Other Admin. Staff Transportation	0	75	291	0	0	0	0	0	0	0	0	366	25
26	Insurance-Prop.Liab.Malpractice	0	741	689	0	0	0	0	0	0	0	0	1,430	26
27	Other (specify):*	(17,288)	3,565	1,597	0	0	0	0	0	0	0	0	(12,126)	27
28	**TOTAL General Administration**	(50,700)	34,618	(184,989)	0	0	0	0	0	0	0	0	(201,071)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(52,300)	36,166	(184,369)	0	0	0	0	0	0	0	0	(200,503)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(11,514)	280	691	0	0	0	0	0	0	0	0	(10,543)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,064	0	0	0	0	0	0	0	0	1,064	32
33	Real Estate Taxes	0	0	628	0	0	0	0	0	0	0	0	628	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,705	736	0	0	0	0	0	0	0	0	2,441	35
36	Other (specify):*	0	0	(7,669)	0	0	0	0	0	0	0	0	(7,669)	36
37	**TOTAL Ownership**	(11,514)	1,985	(4,550)	0	0	0	0	0	0	0	0	(14,079)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(63,814)	38,151	(188,919)	0	0	0	0	0	0	0	0	(214,582)	45

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				EKS MGMT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
SEE ATTACHED SCHEDULES				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE	$	EKS MANAGEMENT		$ 1,471	$ 1,471	1
2	V	7	SCAVENGER		" "		77	77	2
3	V	17	CFO SALARY		" "		5,681	5,681	3
4	V	19	PROFESSIONAL FEES		" "		5,216	5,216	4
5	V	20	WANT ADS		" "		778	778	5
6	V	21	CLERICAL		" "		18,465	18,465	6
7	V	23	SEMINARS		" "		47	47	7
8	V	24	IN-STATE LODGING/MEALS		" "		50	50	8
9	V	25	STAFF TRANSPORTATION		" "		75	75	9
10	V	26	INSURANCE		" "		741	741	10
11	V	27	EMPLOYEE BENEFITS		" "		3,565	3,565	11
12	V	30	SL DEPRECIATION		" "		280	280	12
13	V	35	EQUIPMENT RENT		" "		1,705	1,705	13
14	Total			$			$ 38,151	$ * 38,151	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 52,416	EKS MANAGEMENT		$	$ (52,416)	15
16	V								16
17	V	17	MANAGEMENT FEES	150,000	EMI ENTERPRISES			(150,000)	17
18	V	17	OFFICERS SALARY		" "		9,260	9,260	18
19	V	19	ACCOUNTING FEES		" "		165	165	19
20	V	21	CLERICAL		" "		5,211	5,211	20
21	V	25	STAFF TRANSPORTATION		" "		291	291	21
22	V	26	INSURANCE		" "		632	632	22
23	V	27	EMPLOYEE BENEFITS		" "		1,597	1,597	23
24	V	30	SL DEPRECIATION		" "		209	209	24
25	V	35	AUTO LEASE		" "		736	736	25
26	V								26
27	V	36	OFFICE RENT	7,784	IME REALTY			(7,784)	27
28	V	5	UTILITIES		" "		227	227	28
29	V	6	REPAIRS/MAINTENANCE		" "		393	393	29
30	V	19	PROFESSIONAL FEES		" "		143	143	30
31	V	21	OFFICE EXPENSE		" "		71	71	31
32	V	26	INSURANCE		" "		57	57	32
33	V	30	SL DEPRECIATION		" "		482	482	33
34	V	32	INTEREST		" "		1,064	1,064	34
35	V	33	REAL ESTATE TAX		" "		628	628	35
36	V	36	STORAGE FEES		" "		115	115	36
37	V								37
38	V								38
39	Total			$ 210,200			$ 21,281	$ * (188,919)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATION FROM EMI ENTERPRISES:				SEE ATTACHED				$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT CONSUL	40.00	SCHEDULE	5	7.00	SALARY	9,260	17-7	2
3											3
4											4
5	PHILIP ESFORMES	MGMT CONSULT	MGMT CONSUL	22.50		5	8.00	MGMT FEE	73,000	17-3	5
6											6
7											7
8	ALLOCATION FROM EKS MANAGEMENT:										8
9	AVRUM WEINFELD		CFO			3	6.00	SALARY	5,681	17-7	9
10											10
11											11
12											12
13								TOTAL	$ 87,941		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 3737 W ARTHUR
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	CENSUS DAYS	797,100	13 FACILITIES	$ 29,397	$ 29,397	39,898	$ 1,471	1
2	7	SCAVENGER	" "	797,100	13 FACILITIES	1,544		39,898	77	2
3	17	CFO SALARY	" "	797,100	13 FACILITIES	113,499	113,499	39,898	5,681	3
4	19	PROFESSIONAL FEES	" "	797,100	13 FACILITIES	104,205	93,812	39,898	5,216	4
5	20	WANT ADS	" "	797,100	13 FACILITIES	15,548	360,721	39,898	778	5
6	21	CLERICAL	" "	797,100	13 FACILITIES	368,910		39,898	18,465	6
7	23	SEMINARS	" "	797,100	13 FACILITIES	940		39,898	47	7
8	24	IN-STATE LODGING/MEALS	" "	797,100	13 FACILITIES	994		39,898	50	8
9	25	STAFF TRANSPORTATION	" "	797,100	13 FACILITIES	1,506		39,898	75	9
10	26	INSURANCE	" "	797,100	13 FACILITIES	14,803		39,898	741	10
11	27	EMPLOYEE BENEFITS	" "	797,100	13 FACILITIES	71,229		39,898	3,565	11
12	30	SL DEPRECIATION	" "	797,100	13 FACILITIES	5,592		39,898	280	12
13	35	EQUIPMENT RENT	" "	797,100	13 FACILITIES	34,056		39,898	1,705	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 762,223	$ 597,429		$ 38,151	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 3737 W ARTHUR
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	CENSUS DAYS	797,100	13 FACILITIES	$ 185,000	$ 185,000	39,898	$ 9,260	1
2	19	ACCOUNTING FEES	" "	797,100	13 FACILITIES	3,299		39,898	165	2
3	21	CLERICAL	" "	797,100	13 FACILITIES	104,106	76,720	39,898	5,211	3
4	25	STAFF TRANSPORTATION	" "	797,100	13 FACILITIES	5,805		39,898	291	4
5	26	INSURANCE	" "	797,100	13 FACILITIES	12,620		39,898	632	5
6	27	EMPLOYEE BENEFITS	" "	797,100	13 FACILITIES	31,900		39,898	1,597	6
7	30	SL DEPRECIATION	" "	797,100	13 FACILITIES	4,180		39,898	209	7
8	35	AUTO LEASE	" "	797,100	13 FACILITIES	14,702		39,898	736	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 361,612	$ 261,720		$ 18,101	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY
Street Address: 3737 W ARTHUR
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	268,762	13 + FACIL	$ 7,839	$	7,784	$ 227	1
2	6	REPAIRS/MAINTENANCE	" "	268,762	13 + FACIL	13,572		7,784	393	2
3	19	PROFESSIONAL FEES	" "	268,762	13 + FACIL	4,925		7,784	143	3
4	21	OFFICE EXPENSE	" "	268,762	13 + FACIL	2,448		7,784	71	4
5	26	INSURANCE	" "	268,762	13 + FACIL	1,978		7,784	57	5
6	30	SL DEPRECIATION	" "	268,762	13 + FACIL	16,647		7,784	482	6
7	32	INTEREST	" "	268,762	13 + FACIL	36,747		7,784	1,064	7
8	33	REAL ESTATE TAX	" "	268,762	13 + FACIL	21,685		7,784	628	8
9	35	STORAGE FEES	" "	268,762	13 + FACIL	3,962		7,784	115	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 109,803	$		$ 3,180	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: IME REALTY		X	MORTGAGE			$	$			$ 1,064	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIRST EQUITY		X	WORKING CAPITAL		11/30/01	300,000	440,927	11/30/03	PRIME +	22,229	6
7	INSURANCE FINANCING		X	INSURANCE FINANCING							3,809	7
8												8
9	TOTAL Facility Related						$ 300,000	$ 440,927			$ 27,102	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 300,000	$ 440,927			$ 27,102	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	235,050	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	245,999	2
3. Under or (over) accrual (line 2 minus line 1).	$	10,949	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	248,460	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	259,409	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	200,823	8
	1998	215,360	9
	1999	226,504	10
	2000	232,727	11
	2001	245,999	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOODSIDE EXTENDED CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043406

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-29-401-011-0000	NURSING HOME	$ 245,999.47	$ 245,999.47
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 245,999.47	$ 245,999.47

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,900 B. General Construction Type: Exterior CONCRETE Frame METAL/CONCRETE Number of Stories 1 + BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CEILING LIGHTING			1997	3,746	96	39	96		492	9
10	WATER SOFTENING SYSTEM			1997	6,926	178	39	178		912	10
11	FLOORING			1997	3,910	100	39	100		504	11
12	FLOORING / DOORS / WINDOWS			1998	29,194	748	39	748		3,466	12
13	ROOF			1998	84,450	2,165	39	2,165		10,558	13
14	DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.			1998	30,915	793	39	793		3,876	14
15	PAINTING / DECORATING			1998	15,111	387	39	387		1,758	15
16	FLOORING / DOORS / BATHROOM FIXTURES			1999	11,198	288	39	288		1,132	16
17	CHAIN LINK FENCE			1999	5,100	131	39	131		453	17
18	FLOOR TILES/COVE BASE			2000	22,766	828	27.5	828		2,449	18
19	PAIR OF ALUMINUM DOORS			2000	2,193	80	27.5	80		223	19
20	PLUMBING			2000	9,913	360	27.5	360		765	20
21	PLUMBING / VANITY / SINK / FLOORING			2001	37,788	1,374	27.5	1,374		2,376	21
22	DRAPERIES			2001	7,578	2,425	10	758	(1,667)	1,137	22
23	PAVING			2002	18,562	366	27.5	366		366	23
24	BATHROOM SINKS			2002	3,888	6	27.5	6		6	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - IME REALTY					395		395			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 293,238	$ 10,720		$ 9,053	$ (1,667)	$ 30,473	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 116,828	$ 14,014	$ 9,198	$ (4,816)	8-15 YRS	$ 37,980	71
72	Current Year Purchases	12,646	5,656	625	(5,031)	8-15 YRS	625	72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC - EKS MGMT 280/EMI ENTERP 209/IME REALTY 87		576	576				74
75	TOTALS	$ 129,474	$ 20,246	$ 10,399	$ (9,847)		$ 38,605	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 422,712	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 30,966	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 19,452	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (11,514)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 69,078	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: MAJ ENTERPRISES INC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		112	11/98	$ 563,803	19		3
4	Additions							4
5								5
6								6
7	TOTAL		112		$ 563,803 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 11/01/1998
Ending 10/31/2017

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2003	$ 574,023
13.	12/31/2004	$ 584,243
14.	12/31/2005	$ 594,463

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 19,872 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE:	'01 CHEVY WAGON	$ 699.24	$ 8,461	17
18	BANKING,MAINT,	TOYOTA	448.92	4,176	18
19	MARKETING, NSG,	'01 JEEP GRAND CHEROKEE	600.00	2,400	19
20	ACTIVITIES				20
21	TOTAL		$ 1,748.16	$ 15,037	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 20,746	$		$ 20,746	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			646			646	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			26,552			26,552	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				46,169		46,169	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LABORATORY	39-2					1,801		1,801	13
14	TOTAL			$		$ 47,944	$ 47,970		$ 95,914	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WOODSIDE EXTENDED CARE **#** 0043406 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (33,197)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 75,500)	986,264		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,204		6
7	Other Prepaid Expenses	1,304		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX ESCROW	191,528		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,184,103	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	285,660		15
16	Equipment, at Historical Cost	137,052		16
17	Accumulated Depreciation (book methods)	(127,400)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 295,312	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,479,415	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 106,720	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,651		28
29	Short-Term Notes Payable	440,927		29
30	Accrued Salaries Payable	58,820		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,904		31
32	Accrued Real Estate Taxes(Sch.IX-B)	248,460		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MEMBERS' LOANS	241,723		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,124,205	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,124,205	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 355,210	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,479,415	$	48

***(See instructions.)**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 336,671	1
2	Restatements (describe):		2
3	POST-CLOSING STAFF DEVELOPMENT COST	(14,640)	3
4		(1,155)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 320,876	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	477,334	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(443,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 34,334	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 355,210	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,429,699	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,429,699	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	26,370	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 26,370	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,456,071	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	650,651	31
32	Health Care	1,301,713	32
33	General Administration	944,701	33
	B. Capital Expense		
34	Ownership	921,938	34
	C. Ancillary Expense		
35	Special Cost Centers	95,914	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,976,237	40
41	**Income before Income Taxes (line 30 minus line 40)****	479,834	41
42	**Income Taxes**	(2,500)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 477,334	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,081	2,126	$ 56,259	$ 26.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,507	3,819	68,423	17.92	3
4	Licensed Practical Nurses	15,765	17,199	332,179	19.31	4
5	Nurse Aides & Orderlies	56,815	61,245	501,763	8.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,065	3,438	50,788	14.77	8
9	Activity Director					9
10	Activity Assistants	9,705	10,164	74,071	7.29	10
11	Social Service Workers	1,264	1,317	14,950	11.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,498	18,874	148,053	7.84	15
16	Dishwashers					16
17	Maintenance Workers	2,897	3,009	31,189	10.37	17
18	Housekeepers	13,663	14,218	94,899	6.67	18
19	Laundry	5,073	5,385	35,129	6.52	19
20	Administrator	1,907	2,021	88,515	43.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,719	10,434	88,785	8.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,034	1,087	8,483	7.80	31
32	Other Health Ca MDS/QUAL ASSU	8,500	8,523	81,515	9.56	32
33	Other(specify) SECURITY	1,005	1,040	8,302	7.98	33
34	TOTAL (lines 1 - 33)	153,498	163,899	$ 1,683,303 *	$ 10.27	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 11,600	1-3	35
36	Medical Director	O	9,125	9-3	36
37	Medical Records Consultant	N	2,591	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,382	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		1,000	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,856	11-3	44
45	Social Service Consultant	E	4,616	12-3	45
46	Other(specify)	S			46
47	PSYCHO-SOCIAL CONSULTANT		1,020	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 38,190		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	44	291	10-3	52
53	TOTAL (lines 50 - 52)	44	$ 291		53

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LES OKUN	ADMIN	0	$ 88,515
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,515

B. Administrative - Other

Description		Amount
EMI ENTERPRISES	MGMT FEES	$ 150,000
PHILIP ESFORMES	MGMT FEES	73,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 223,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 3,564
MAXXSOURCE	DATA PROCESSING	1,500
HDSI	DATA PROCESSING	6,159
LTC SOLUTION	DATA PROCESSING	1,320
NCS	DATA PROCESSING	337
MUTUAL OF OMAHA	DATA PROCESSING	272
KBKB	ACCOUNTING	11,100
PERSONNEL PLANNERS	UNEMPLOYMENT CONS.	979
RICHARD PEELO	M/C COST REPORTING	4,500
SACHNOFF & WEAVER	LEGAL	147
PROCLAIM AMERICA	INSUR.LIAB ASSESSMENT	2,495
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 32,373

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 62,375
Unemployment Compensation Insurance		22,325
FICA Taxes		128,288
Employee Health Insurance		52,300
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		5,475
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 270,763

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	909
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	28,458
TRUST/FRANCHISE/CONTRIB/ETC	4,954
LICENSES & PERMITS	1,005
DUES & SUBSCRIPTIONS	3,166
MGMT CO ALLOCATION-EKS	778
TRUST/FRANCHISE/CONTRIB/ETC	(4,954)
Less: Public Relations Expense	(27,818)
Non-allowable advertising	(145)
Yellow page advertising	(495)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,858

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MGMT CO ALLOCATION-EKS	50
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 50

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	1999	$ 1,851	3	$ 309	$ 617	$ 617	$ 308	$	$	$	$	$
2	PAINT/DECORATING	2002	1,565					261	522	522	260		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,416		$ 309	$ 617	$ 617	$ 569	$ 522	$ 522	$ 260	$	$

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $ 3,166**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **NO** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **61,320**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: WOODSIDE EXTENDED CARE #0043406 **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,600	
	REPAIRS & MAINTENANCE		570	
			0	12,170
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		7,210	
			0	7,210
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		10,951	
	ELECTRICITY		48,189	
	WATER		35,705	
	CABLE TV - LOBBY		0	
			0	94,845
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,177	
	PAINTING & DECORATING		1,565	
	BUILDING REPAIRS		3,070	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		8,525	
	ELEVATOR MAINTENANCE & REPAIR		1,320	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,817	
	FIRE SERVICE		3,346	
			0	
			0	
			0	20,820
7	**OTHER**			
	SCAVENGER		5,932	
	SECURITY SERVICE		383	6,315
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,125	9,125

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	291	
	LABORATORY & XRAY EXPENSE		2,644	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B 47-2	1,020	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,591	
	PHARMACY CONSULTANT	XVIII B 39-2	5,382	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL CONSULTANT		3,025	
			0	14,953
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	1,000	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,000
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,856	
			0	2,856
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	4,616	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	4,616
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WOODSIDE EXTENDED CARE **#0043406** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		4,002	4,002
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	223,000	223,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,151	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	19,222	
			0	32,373
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	**27,818**	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	145	
	EMPLOYEE WANT ADS	XIX F	909	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	3,166	
	LICENSES & PERMITS	XIX F	1,005	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	495	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	200	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,754	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	38,492
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		44	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		52,416	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,436	
	MESSENGER SERVICE		0	
			0	71,896

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	128,288	
	UNEMPLOYMENT COMPENSATION	XIX D	22,325	
	WORKERS COMPENSATION INSURANC	XIX D	62,375	
	HOSPITALIZATION INSURANCE	XIX D	52,300	
	EMPLOYEE BENEFITS - OTHER	XIX D	5,475	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	270,763
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,512	2,512
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,874	3,874
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		87,712	87,712
27	**OTHER**			
	BAD DEBTS	VI 24	17,288	
			0	17,288

GRAND TOTAL COLUMN 3 OTHER 925,822

WOODSIDE EXTENDED CARE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	138,602	PATIENT MEALS	119694
LESS SALES TAX	(604)	ADD EMPLOYEE MEALS	0
NET FOOD	137,998	TOTAL MEALS/YEAR	119694
TOTAL PATIENT CENSUS	39,898	NET FOOD	137998
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	119694
TOTAL PATIENT MEALS	119694	COST PER MEAL	1.15
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

WOODSIDE EXTENDED CARE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S										4,355,491	
		NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT		1,301,713	270,763	287,200	52,915	310,536	673,938	61,320	921,938		1,683,303
ADJUSTMENTS:											
	EQUIPMENT RENTAL/AUTO LEASE	1,457		0			15,037		(16,494)		
	CABLE TV			0			0				
	CONTRACT NURSING										291
	INTEREST INCOME							(2)			
	NET VENDING COMMISSIONS										
	EMPLOYEE PHYSICAL EXAMS		0				0				
	INSURANCE - EXECUTIVE LIFE		0				0				
	MANAGEMENT FEES								0		
	O2 INCOME										
	BAD DEBTS						(17,288)	17,288			
	DISCOUNTS LOST							0			
	ANCILLARIES								0		
	SETTLEMENT INTEREST										
	RECLASSED SALARIES	(22,451)	0	0	0	0	22,451	0	0		
	PROFIT SHARING	0	0	0	0	0	0	0	0		
	PRIOR EXPENSES	0	0	0	0	0	0	(4,664)	0		
	BENEFITS REBILLED	0	0	0	0	0	0	0	0		
	RENT/INTEREST	0	0	0	0	0	0	0	0		
	NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS		1,280,719	270,763	287,200	52,915	310,536	694,138	73,942	905,444	3,875,657	1,683,594
PER FINANCIAL STATEMENTS		1,280,719	270,763	287,200	52,915	310,536	694,138	73,942	905,444	479,834	1,683,594
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS										479,834	

WOODSIDE EXTENDED CARE - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		40,880			40880			0	40992		
CENSUS DAYS		39,898			38836			1,062	39632		
OCCUPANCY %		97.60%			95.00%				96.68%		
SALARIES											
TOTAL General Services	8-1	317,572	8.44%	7.96	290398	8.07%	7.48	27,174	274957	8.16%	6.94
Social Services	12-1	14,950	0.40%	0.37	0	0.00%	0.00	14,950	0	0.00%	0.00
TOTAL Health Care and Programs	16-1	1,188,431	31.59%	29.79	1094384	30.43%	28.18	94,047	1075266	31.90%	27.13
Clerical & General Office Expenses	21-1	88,785	2.36%	2.23	81082	2.25%	2.09	7,703	83208	2.47%	2.10
TOTAL General Administration	28-1	177,300	4.71%	4.44	180263	5.01%	4.64	(2,963)	179149	5.31%	4.52
TOTAL Operation Expense	29-1	1,683,303	44.75%	42.19	1565045	43.51%	40.30	118,258	1529372	45.37%	38.59
ADJUSTED TOTALS											
Food	2-8	137,998	3.67%	3.46	145529	4.05%	3.75	(7,531)	130235	3.86%	3.29
Heat and Other Utilities	5-8	95,072	2.53%	2.38	72711	2.02%	1.87	22,361	65116	1.93%	1.64
Maintenance	6-8	70,337	1.87%	1.76	73952	2.06%	1.90	(3,615)	65310	1.94%	1.65
TOTAL General Services	8-8	651,219	17.31%	16.32	626336	17.41%	16.13	24,883	579022	17.18%	14.61
Administrative	17-8	176,456	4.69%	4.42	195835	5.44%	5.04	(19,379)	177823	5.27%	4.49
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	37,897	1.01%	0.95	37476	1.04%	0.96	421	45182	1.34%	1.14
Fees, Subscriptions, Promotions	20-8	5,858	0.16%	0.15	16266	0.45%	0.42	(10,408)	14919	0.44%	0.38
License Fee-IDPA	Pg21	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
License Fee-Other	Pg21	1,005	0.03%	0.03	1837	0.05%	0.05	(832)	1744	0.05%	0.04
Clerical & General Office Expenses	21-8	151,503	4.03%	3.80	153334	4.26%	3.95	(1,831)	125130	3.71%	3.16
Employee Benefits & Payroll Taxes	22-8	270,763	7.20%	6.79	274097	7.62%	7.06	(3,334)	227218	6.74%	5.73
Payroll Taxes	Pg21	150,613	4.00%	3.77	157730	4.39%	4.06	(7,117)	154614	4.59%	3.90
W/C Insurance	Pg21	62,375	1.66%	1.56	64291	1.79%	1.66	(1,916)	43331	1.29%	1.09
Health Insurance	Pg21	52,300	1.39%	1.31	48076	1.34%	1.24	4,224	27403	0.81%	0.69
Inservice Training & Education	23-8	2,559	0.07%	0.06	1900	0.05%	0.05	659	2208	0.07%	0.06
Travel and Seminar	24-8	50	0.00%	0.00	202	0.01%	0.01	(152)	0	0.00%	0.00
Other Admin. Staff Transportation	25-8	4,240	0.11%	0.11	5299	0.15%	0.14	(1,059)	4512	0.13%	0.11
Insurance-Prop.Liab.Malpractice	26-8	89,142	2.37%	2.23	60823	1.69%	1.57	28,319	52260	1.55%	1.32
Other (specify):*	27-8	5,162	0.14%	0.13	6681	0.19%	0.17	(1,519)	6724	0.20%	0.17
TOTAL General Administration	28-8	743,630	19.77%	18.64	751913	20.90%	19.36	(8,283)	655976	19.46%	16.55
TOTAL Operation Expense	29-8	2,696,562	71.69%	67.59	2592167	72.07%	66.75	104,395	2406391	71.38%	60.72
Real Estate Taxes	33-3	259,409	6.90%	6.50	239007	6.64%	6.15	20,402	237764	7.05%	6.00
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	3,761,655	100.00%	**94.28**	3596828	100.00%	**92.62**	164,827	3371107	100.00%	**85.06**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1203687.3	32.00%	**30.17**	1186582.1	32.99%	**30.55**	17,105	1075246.3	31.90%	**27.13**

WOODSIDE EXTENDED CARE - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 569 from Page 22 and -1565 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-1064 ALLOC 1064
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-971 ALLOC 971
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 = Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.